Culture Bound Syndrome or Idiom of Distress?: A Case of Brief Jinn Possession with Atypical Features in an Afghani Patient

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OBJECTIVES

1. Defining culture-bound syndrome (CBS)
2. Differentiating between CBS and idioms of distress
3. Learning about assessing patients through a cultural lens

BACKGROUND

Culture bound syndromes (CBS) present in myriad forms, often confusing clinical diagnosis and management. This becomes particularly problematic when features of culture bound syndromes overlap with classical western psychiatric illnesses. Certain CBSs have been well-described and studied across a variety of ethnic groups, including but not limited to ataque de nervios among Spanish-speakers in the Caribbean and the Americas[1], dhat in the Indian subcontinent[2], hikikomori in Japan[3], hwa-byung amongst Korean women[4], and koro across a number of Asian and African societies[5]. However, comparatively less attention has been directed at CBS's in Muslim cultures. One CBS that has been observed across Islamic societies is that of "*jinn* (or *djinn*)", often characterized by belief in possession by spirits or devils resulting in transient but severe psychotic symptoms such as hallucinations. Recent classifications have recommended using a more broad term, cultural concepts of distress, to address 3 aspects of what has been called CBS's: cultural syndromes, cultural idioms of distress (IOD), and cultural explanations. Here we present a case of a cultural idiom of distress, best understood as a phenotypic expression of *jinn* possession or influence. This is confounded by atypical clinical features such as panic disorder and globus hystericus along with ethnic variations within the Afghani cultural experience, more accurately described as *peryan*[7].

CASE DESCRIPTION

Initial presentation:

The patient was a 22-year-old Pashto-speaking woman with no significant past medical or psychiatric history who presented to the emergency department (ED) with "altered mental status". She was brought in by her English-speaking brother-in-law who provided translation, contextual information, and support. The patient was minimally cooperative with examination. Her brother-in-law reported that one hour prior to presenting, the patient was calmly drinking tea and suddenly threw her head back and clasped her hands on her throat. After the incident, she had not spoken and seemed confused, prompting arrival to the ED.

ED examination revealed a well-nourished, visibly distressed woman again clenching her hands around her neck, appearing to choke herself. She was medicated with intramuscular (IM) midazolam 7 mg (5 mg then 2 mg) as well as IM haloperidol 5 mg and lorazepam 2 mg for persistent agitation and potential self-harm. She was noted to be shouting a phrase repeatedly to her brother-in-law in Pashto, which he interpreted to the medical team as her seeing a being in the room who was asking to kill the patient.

Medical examination was unremarkable, including vitals, physical examination, laboratory tests and CT head. Historically, the patient had a normal spontaneous vaginal delivery 4 months prior to this incident with no reported gestational, perinatal, or postpartum complications. There were no other noted medical and surgical histories, and she did not take any prescribed medications or treatments. Socially, the patient lived with her husband, her 4-month-old child, and her in-laws in the US after having moved from her native Afghanistan 11 months prior.

CASE DESCRIPTION CONTINUED

Psychiatric evaluation:

The patient was maintained on constant observation until seen by the consult psychiatry team, who were consulted for "self-harming behavior" and hallucinations. Per staff the patient slept overnight with no further incidents. Psychiatric interview was conducted with a Pashto-speaking phone interpreter. The patient appeared bright, well-related, and cooperative. She communicated that she felt well and wanted to return home to her infant.

She reported that prior to admission, she felt she was choking when drinking tea and had a sensation in her throat. In the ED the choking sensation recurred so she placed her hands on her throat not to harm or kill herself, but to communicate the sensation. During the choking event she witnessed a woman clad all in white standing in her room. She knew this woman wanted to harm her but denied feeling scared of her. Once gone, she felt sure the woman would not come back, but could not elaborate. She denied any history of paranoia, delusions, or hallucinations. She also denied history of depression, anxiety, trauma, self-injurious behavior, or psychiatric care, and specifically denied current or past suicidal or homicidal ideation. She reported she felt safe in the hospital and at home.

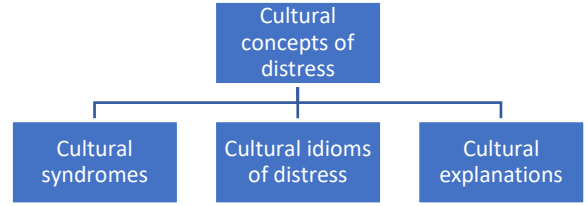
Her husband provided collateral. He emphasized that his wife was "ok now," reporting this was a phenomenon common in "our culture" in which a woman is possessed by a spirit and simply needs to expel it in order to recover. He added that "women often appear this way," describing certain behaviors such as "moaning, shouting in distress, flailing arms, pushing people away." He added that someone may also "summon a shaman to complete a ritual to purge the spirit." Neither the patient nor family members appeared surprised or distressed by the "woman who wasn't there" and dismissed any further safety concerns.

Psychiatry recommended that given lack of suicidality and current psychosis patient was safe to release at her request. Mental health outpatient services were offered, but she politely declined. There were no further events in the short hospital stay and she was discharged later that day.

Classic *jinn* possession	Our case
• Across Muslim cultures	• Specifically Afghanistan (*peryan)*
• Female or child	• Young woman
• Provoking trauma / distress	• Post-partum distress, immigration
• Seeing spirit or feeling of possession/ influence of spirit	• Feeling of spirit influencing her/ transient possession
• Accompanying gesticulations, inappropriate emotional expressions, hallucinations	• Change in behavior in response to spirit
	• Additional somatic complaints (Globus hystericus)

DISCUSSION

This case illustrates the overlap between certain culturally acceptable experiences and frank psychosis, while also highlighting the degree of variability between presentations of CBS across ethnic groups. Furthermore, as there were differences between the *peryan* and that of *jinn* possession, this case highlights how cultural IOD's potentially provide a more accurate lens through which to view a patient's symptoms. There are interesting dynamics involved in this case – most notably, the fact that this patient, being a recent immigrant, is now interacting with the western medical paradigm. One may make the distinction that culture bound syndromes are considered codified and immutable by virtue of their presence in the DSM – whereas idioms of distress may change as cultures overlap due to the pressures of globalization and immigration. Where hallucinations are nearly always seen as aberrant in Western medicine, the same cannot be generalized to other cultures. This implies that symptomatology may not be universally "abnormal" and may be actively changing with globalization and migration[8].



CONCLUSION

There is a paucity of literature and instruction regarding various culture bound syndromes and the relevant approaches to evaluation, diagnosis, and treatment. Furthermore, the assumption that *jinn* possession is monolithic across the Muslim world fails to recognize local ethnic differences which may better be understood through the more flexible lens of cultural idioms of distress. More investigation into Afghani specific cultural IODs is warranted.

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